TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MEMORIAL HERMAN SURGICAL HOSPITAL

Respondent Name
UNITED AIRLINES, INC.

MFDR Tracking Number
M4-17-2869-01

Carrier's Austin Representative
Box Number 48

MFDR Date Received
May 30, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claim listed above was not processed according to Texas fee guidelines for outpatient services."

Amount in Dispute: $2,518.65

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Coventry stands behind our review. . . . PPO reduction is applied."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 6, 2016	Outpatient Hospital Services	$2,518.65	$194.79

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.240 sets out requirements for paying or denying medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.403 sets out the acute care hospital fee guideline for outpatient services.
4. Texas Insurance Code Chapter 1305 regulates certified workers' compensation health care networks.
5. Texas Labor Code Sections 413.011(d-1) to (d-6) [expired] and 413.0115, as well as former division Rule at 28 Texas Administrative Code §133.4, set out certain provisions related to informal and voluntary insurance networks.
6. Texas Labor Code §413.031 entitles health care providers to a review of services if payment is reduced.

7. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 00109 – (45) CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT
   - 00950 – THIS BILL IS A RECONSIDERATION OF A PREVIOUSLY REVIEWED BILL. ALLOWANCE AMOUNTS DO NOT REFLECT PREVIOUS PAYMENTS.
   - 26951 – WE ARE UNABLE TO RECOMMEND AN ADDITIONAL ALLOWANCE SINCE THIS CLAIM WAS PAID IN ACCORDANCE WITH THE STATE'S FEE SCHEDULE GUIDELINES, FIRST HE
   - 26458 – THIS BILL WAS REVIEWED IN ACCORDANCE WITH YOUR COVENTRY CONTRACT. FOR QUESTIONS, PLEASE CALL 1-800-937-6824.
   - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - W3 – Request for reconsideration.
   - 59 – Processed based on multiple or concurrent procedure rules.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Are the disputed services subject to a contractual agreement between the parties to this dispute?
3. What is the applicable rule for determining reimbursement for the disputed services?
4. What is the recommended payment for the services in dispute?
5. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 26458 – "THIS BILL WAS REVIEWED IN ACCORDANCE WITH YOUR COVENTRY CONTRACT. FOR QUESTIONS, PLEASE CALL 1-800-937-6824."

   The respondent states that a "PPO reduction is applied."

   Per Texas Labor Code §413.011(d-1) to (d-6) and §413.0115, as well as 28 Texas Administrative Code §133.4, other than for certain pharmacy, durable medical equipment, or home health care services, insurance carriers may not contract with informal or voluntary insurance networks to provide workers' compensation services effective January 1, 2011, unless such a former informal or voluntary network was certified as a workers' compensation health care network under Chapter 1305, Insurance Code, no later than January 1, 2011. Further, the injured employee must be enrolled in the certified workers' compensation network and the certified workers' compensation network must be named on the explanation of benefits, per 28 Texas Administrative Code §133.240(f)(15).

   Based on information maintained by the division, the injured employee is not enrolled in a worker's compensation health care network certified in accordance with Insurance Code Chapter 1305. The insurance carrier has never reported to the division that the injured employee was enrolled in certified workers' compensation health care network and has not provided any information with their response to support that the injured employee has been enrolled in such a network.

   28 Texas Administrative Code §133.240(f)(15) requires that the insurance carrier shall include the "workers' compensation health care network name (if applicable)" on the paper form of an explanation of benefits.

   While the explanation of benefits does mention a Coventry contract and a Coventry workers' comp portal, as well as the First Health Network, neither the First Health Network or "Coventry" are the names of a specific workers' compensation healthcare network registered with the division as certified Texas workers' compensation health care networks established in accordance with Insurance Code Chapter 1305. "Coventry" is rather a trademark under which a variety of different networks (each with separate names) are marketed.

There are two certified worker's compensation networks listed in division records that include the word "Coventry" in their name, and three with the words "First Health"; however, the above information does not match division records and is not sufficient for a health care provider or injured employee to identify which entity is being asserted as the network, or even that the entity is a *Texas workers' compensation network* certified in accordance with Insurance Code Chapter 1305. Accordingly, based on the information presented to MFDR, the division finds that the insurance carrier has failed to meet the requirements of Rule §133.240(f)(15).

The respondent did not submit any information regarding a contract between the insurance carrier or self-insured (United Airlines) and a specific certified workers' compensation healthcare network within the Coventry umbrella of networks or a First Health certified workers' compensation health care network. Nor did it present any information to support the health care provider is contracted with such a network. Furthermore, the respondent did not present any information to support the injured employee is enrolled in such a network, or to identify *which* network the employee was enrolled in. Accordingly, based on the information presented to MFDR, the division finds that the insurance carrier has failed to support that a contractual or network agreement applies to the services in this dispute.

Moreover, in the absence of any evidence to support that the insurance carrier presented clear information to the health care provider that the injured employee was enrolled in a certified workers' compensation health care network (HCN) prior to the filing of a medical fee dispute—whether as a plain language notice on an explanation of benefits issued before the filing of a medical fee dispute, or otherwise—the respondent has failed to meet the requirements for raising such a defense.

28 Texas Administrative Code §133.307(d)(2)(F) requires that "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review."

While the denial reason on the EOB references a "Coventry contract," this falls far short of a plain language notice informing the provider that the injured employee is enrolled in a certified workers' compensation health care network, or of any of the rights and responsibilities of the provider that appertain thereto.

Upon review of the above information, the division concludes the insurance carrier has waived the right to raise new denial reasons or defenses not presented to the health care provider prior to the filing of the MFDR request. As found above, the insurance carrier failed to identify on the explanation of benefits the name of a certified workers' compensation network in accordance with the requirements of Rule §133.240(f)(15), and did not present documentation that the health care provider was notified of the involvement of a certified workers' compensation health care network, and therefore per Rule §133.307(d)(2)(F) any such new defenses or denial reasons may not be considered in this review.

Based on the information presented by the respondent for review, the division concludes the respondent has failed to support that the injured employee is enrolled in a certified worker's compensation HCN. Moreover, even were the injured employee enrolled in such a network, the insurance carrier did not include a name of a registered workers' compensation HCN on the EOB in accordance with the medical bill processing requirements of Rule §133.240(f)(15). The insurance carrier thus failed to give plain language notice to the provider that a network was involved or that any special requirements were applicable and has therefore waived the right to assert that network provisions apply. The division concludes it has authority to review the fee issues in this dispute and will proceed to review them under applicable division rules and fee guidelines.

2. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.

3. This dispute regards outpatient hospital facility services with payment subject to 28 Texas Administrative Code §134.403, which requires the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount (including outlier payments) applying the effective Medicare Outpatient Prospective Payment System (OPPS) formula and factors, published annually in the Federal Register, with modifications as set forth in the rule. Medicare OPPS formulas and factors are available from http://www.cms.gov.

   Rule §134.403(f)(1) requires the sum of the Medicare facility specific amount and any applicable outlier payment be multiplied by 200 percent, unless a facility or surgical implant provider requests separate payment of implantables. Separate reimbursement for implantables was not requested.

4. Medicare's Outpatient Prospective Payment System (OPPS) assigns an Ambulatory Payment Classification (APC) for billed services based on procedure codes and supporting documentation. The APC determines the payment rate. Hospitals may be paid for more than one APC per encounter. Payment for ancillary items and for services without procedure codes is packaged into the APC payment. The Centers for Medicare and Medicaid Services (CMS) publishes quarterly lists of APC rates in the OPPS final rules, available from www.cms.gov.

   Reimbursement for the disputed services is calculated as follows:

   - Procedure code 29876, December 6, 2016, has status indicator T, denoting significant outpatient procedures subject to multiple-procedure reduction. The highest paying status T unit is paid at 100%; all others at 50%. This procedure is paid at 100% and assigned APC 5122. The OPPS Addendum A rate is $2,395.59. This is multiplied by 60% for an unadjusted labor amount of $1,437.35, which is multiplied by the facility wage index of 0.9653 for an adjusted labor amount of $1,387.47. The non-labor related portion is 40% of the APC rate, or $958.24. The sum of the labor and non-labor portions is $2,345.71. The cost of services does not exceed the fixed-dollar threshold of $3,250. The outlier payment is $0. The Medicare facility specific amount of $2,345.71, is multiplied by 200% for a MAR of $4,691.42.
   - Procedure code 29881, December 6, 2016, has status indicator T, denoting significant outpatient procedures subject to multiple-procedure reduction. The highest paying status T unit is paid at 100%; all others at 50%. This procedure is paid at 50% and is also assigned APC 5122. The OPPS Addendum A rate is $2,395.59. This is multiplied by 60% for an unadjusted labor amount of $1,437.35, which is multiplied by the facility wage index of 0.9653 for an adjusted labor amount of $1,387.47. The non-labor related portion is 40% of the APC rate, or $958.24. The sum of the labor and non-labor portions is $2,345.71. The cost of services does not exceed the fixed-dollar threshold of $3,250. The outlier payment is $0. The Medicare facility specific amount (including multiple-procedure payment reduction) of $1,172.86, is multiplied by 200% for a MAR of $2,345.72.
   - Procedure codes J0360, J1100, J1885, J2001, J2175, J2405, J2550, and J3010 have status indicator N, denoting packaged codes integral to the total service package with no separate payment; reimbursement for these items is included with payment for the primary services.

   Note: the insurance carrier incorrectly calculated payment based on a wage index of 0.9615. However, the services were performed on December 6, 2016. While this date falls within the 4th quarter of Calendar Year 2016, it falls within the first quarter of Federal Fiscal Year 2017. According to Medicare payment policies (barring updates and correction notices) the Hospital Outpatient Prospective Payment System factors and formulas are effective during the Calendar Year. However, the Wage Index is effective for the duration of the Federal Fiscal Year, which begins on October 1st. Consequently, this facility's wage index for the Houston/Woodlands/Sugarland area is 0.9653, per Medicare's Wage Index Table 3-CN, effective October 1, 2016 (for Federal Fiscal Year 2017).

5. The total recommended reimbursement for the disputed services is $7,037.14. The insurance carrier has paid $6,842.35, leaving an amount due to the requestor of $194.79. This amount is recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The Division would like to emphasize that the findings and decision in this dispute are based on the evidence presented by the requestor and respondent available at the time of review. Even though all the evidence was not discussed, it was considered.

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $194.79.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $194.79, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	July 31, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.